Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT REHABILITATION CENTERS
C/O THE MORRIS LAW FIRM
702 S BECKLEY AVE
DALLAS TX 75203

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-06-2060-01

MFDR Date Received
November 21, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier has failed to provide the original response EOB's for the date of 2/4/05, 3/10/05, 3/24/05, and 4/19/05. The carrier has also failed to provide Reconsideration Explanation of Benefits and/or medical audit summaries within the required 28-day period for the dates of 2/4/05, 3/10/05, 3/24/05, and 4/19/05. . . . DOS 2/4/05, 3/10/05, 3/24/05, and 4/19/05: No EOBs were received for these services. DOS2/10/05 through 3/2/05, 3/7/05, 3/8/05, 3/14/05, 3/17/05, 3/21/05, and 4/4/05: According to the TWCC, the provider followed all fee guidelines. . . . DOS 3/3/05: These services are not included or in any other services provided to the patient on that date. Dos 3/7/05 (95833): Services were billed only once and remain unpaid, not a duplicate bill."

Amount in Dispute: $2,886.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:
DOS 2/4/05 and 3/10/05: "Carrier has not received original billing or request for recon per 133.304, please dismiss"
CPT code 99213 DOS 2/10/05-3/21/05: "Denied Incd to code 98940"
CPT code 99373: "Docu does not support service"
DOS 3/24/05: "Carrier agrees to pay per MFG"
DOS 4/4/05: "Carrier already paid"
DOS 4/14/05: "Agree to pay per MFG"

Response Submitted by: The Hartford Medical

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2005 to April 19, 2005	Professional Medical Services	$2,886.58	$749.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §129.5 sets out guidelines related to work status reports.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. 28 Texas Administrative Code §134.202 sets out the applicable fee guideline for professional medical services.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. This request for medical fee dispute resolution was received by the Division on November 21, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 2, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. The requestor submitted a revised *Table of Disputed Services* on September 9, 2008. The requestor's revised Table will be used as the basis for this review.
8. The insurance carrier reduced/denied payment for disputed services using the following reason codes:
   - W1 – WC STATE FEE SCHED ADJUST. REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.
   - W1 – WC STATE FEE SCHEDULE ADJUSTMENT. REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAIDE AT THIS TIME.
   - 97 – PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX. INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED.
   - F – REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED.
   - F – THE SERVICES LISTED UNDER THIS PROCEDURE CODE ARE INCLUDED IN A MORE COMPREHENSIVE CODE WHICH ACCURATELY DESCRIBES THE ENTIRE PROCEDURE(S) PERFORMED.
   - F – OUR RECORDS INDICATE THE INJURED WORKER IS CURRENTLY ENROLLED IN A SINGLE OR INTERDISCIPLINARY PROGRAM.
9. Additionally, the insurance carrier reduced payment for some disputed services with notation/comment that: "REDUCTION OF CHARGES HAS BEEN APPLIED AS A RESULT OF A NEGOTIATED DISCOUNT OBTAINED THROUGH CONCENTRA PREFERRED SYSTEMS. QUESTIONS REGARDING THIS REDUCTION SHOULD BE DIRECTED TO CPS AT 1-877-306-7635."

Issues

1. Did the requestor establish convincing evidence of carrier receipt of a request for explanation of benefits?
2. Are the disputed services subject to a contractual fee arrangement?
3. Did the insurance carrier support the reasons for denial of procedure code 99213?
4. Is the requestor entitled to additional reimbursement?

Findings

1. No explanations of benefits were found with the submitted materials for dates of service February 4, 2005; March 10, 2005; March 24, 2005; and April 19, 2005. The Requestor's position statement asserts that no EOBs for these services were provided by the insurance carrier. The Respondent's position statement asserts that no original billing or request for reconsideration was received from the provider. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." The Requestor submitted a certified mail receipt signed by an agent of the insurance carrier sufficient to establish convincing evidence of carrier receipt of the provider request for an EOB in accordance with 28 TAC § 133.307(e)(2)(B). The Respondent has not submitted the missing EOBs for review as required per 28 TAC § 133.307(e)(3)(B) and/or §133.307(j)(1)(C). These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. The insurance carrier reduced payment for date of service April 4, 2005 with additional comment indicating that "REDUCTION OF CHARGES HAS BEEN APPLIED AS A RESULT OF A NEGOTIATED DISCOUNT OBTAINED THROUGH CONCENTRA PREFERRED SYSTEMS. QUESTIONS REGARDING THIS REDUCTION SHOULD BE DIRECTED TO CPS AT 1-877-306-7635." No documentation was submitted to support a negotiated discount between the parties to this dispute or that the insurance carrier was entitled to access a contractual fee arrangement between the health care provider and a third party. This reduction reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The insurance carrier denied disputed services billed under procedure code 99213 for dates of service February 10, February 11, February 17, February 18, February 21, February 24, March 2, March 3, March 7, March 8, March 10, March 14, March 17, March 21, and March 24, 2005, with reason codes 97 – "PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX. INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED" and F – "REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED." Per 28 Texas Administrative Code §134.202(b), "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Per Medicare payment policy, procedure code 99213 may not be reported with procedure code 98940 on the same date of service. Payment for services represented by procedure code 99213 is included in the reimbursement for procedure code 98940. Review of the submitted medical bills finds that procedure code 99213 was reported with procedure code 98940 on the disputed dates of service. The insurance carriers' denial reasons are supported. Additional reimbursement is not recommended.

4. This dispute relates to professional medical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202(c), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." Reimbursement for the disputed services is calculated as follows:

   - The Medicare rate for Procedure code 99213, date of service February 4, 2005, is $54.65. 125% of this amount is $68.31. This amount is recommended.
   - Per Medicare payment policy, reimbursement for procedure code A4556, date of service February 4, 2005, is included in the payment for other services performed on the same date. The cost of supplies used in furnishing covered therapy is bundled and is not separately payable. Review of the requestor's S.O.A.P. note finds notation that the injured employee "was given electrodes today in order to receive modalities." Documentation supports that the electrodes were to be used in furnishing covered therapy and are not separately reimbursable. Additional payment is not recommended.
   - As stated above, procedure code 99213 is not separately reimbursable when reported with procedure code 98940 on the same date of service. Additional payment for these services is not recommended for dates of service February 10, February 11, February 17, February 18, February 21, February 24, March 2, March 3, March 7, March 8, March 10, March 14, March 17, March 21, March 24, and April 19, 2005.
   - The Medicare rate for Procedure code 97110, date of service March 10, 2005, is $28.91. This amount multiplied by 4 units is $115.64. 125% of this amount is $144.55. This amount is recommended.
   - The Medicare rate for Procedure code 98940, date of service March 10, 2005, is $26.89. 125% of this amount is $33.61. This amount is recommended.
   - The Medicare rate for Procedure code 97140, date of service March 10, 2005, is $27.33. 125% of this amount is $34.16. This amount is recommended.
   - The Medicare rate for Procedure code G0283, date of service March 10, 2005, is $11.72. 125% of this amount is $14.65. This amount is recommended.
   - The Medicare rate for Procedure code 97110, date of service March 24, 2005, is $28.91. This amount multiplied by 4 units is $115.64. 125% of this amount is $144.55. This amount is recommended.
   - The Medicare rate for Procedure code 98940, date of service March 24, 2005, is $26.89. 125% of this amount is $33.61. This amount is recommended.
   - The Medicare rate for Procedure code 97140, date of service March 24, 2005, is $27.33. 125% of this amount is $34.16. This amount is recommended.
   - The Medicare rate for Procedure code G0283, date of service March 24, 2005, is $11.72. 125% of this amount is $14.65. This amount is recommended.

- Procedure code 96004, date of service April 4, 2005, is defined as physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Review of the submitted medical documentation finds that this service is not supported as billed. Reimbursement is not recommended.
- Per 28 Texas Administrative Code §129.5(j), reimbursement for Division specific code 99080-73, date of service April 4, 2005, is $15.00. Review of the submitted documentation finds that the insurance carrier has paid $15.00. No additional payment is recommended.
- The Medicare rate for Procedure code 97110, date of service April 19, 2005, is $28.91. This amount multiplied by 4 units is $115.64. 125% of this amount is $144.55. This amount is recommended.
- The Medicare rate for Procedure code 98940, date of service April 19, 2005, is $26.89. 125% of this amount is $33.61. This amount is recommended.
- The Medicare rate for Procedure code 97140, date of service April 19, 2005, is $27.33. 125% of this amount is $34.16. This amount is recommended.
- The Medicare rate for Procedure code G0283, date of service April 19, 2005, is $11.72. 125% of this amount is $14.65. This amount is recommended.

The request for additional reimbursement is supported. The requestor is entitled to additional reimbursement for the services in dispute. The total recommended additional payment is $749.22.

Conclusion

For the reasons stated above, the requestor has established that additional reimbursement is due. As a result, the amount ordered is $749.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $749.22, plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	March 11, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.